APPEAL NO. 120068
FILED MARCH 12, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on December 7, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the compensable injury of [date of injury], does not extend to degenerative disc disease at L3-4, L4-5, and L5-S1; (2) the compensable injury of [date of injury], does extend to a lumbar disc herniated nucleus pulposus (HNP), spondylolisthesis and spondylosis at L3-4, L4-5, L5-S1, and lumbar radiculopathy; and (3) the claimant's (respondent) impairment rating (IR) is 25%. The appellant (self-insured) appeals the hearing officer's determination of the extent of injury favorable to the claimant and the determination of the claimant's IR. The claimant responded, urging affirmance of the appealed determinations.

DECISION

Affirmed in part as reformed; reversed and rendered in part; and reversed and remanded in part.

The parties stipulated that on [date of injury], the claimant sustained a compensable injury. Although not noted in the decision and order, a review of the record reflects that the parties stipulated that maximum medical improvement (MMI) was reached by the claimant on February 2, 2011. The Benefit Review Conference Report which was admitted into evidence as Hearing Officer's Exhibit No. 1, also reflects the parties agreed that the claimant's MMI date is February 2, 2011.

The claimant testified that he fell approximately four feet while descending from a fire truck, landing on his back. The claimant sought medical treatment on September 23, 2009. His initial medical records indicate the claimant was started on a conservative course of therapy for his back and x-rays were ordered. After the x-rays were taken, the claimant was referred to another doctor, [Dr. D] for an orthopedic evaluation. The claimant underwent an EMG and was subsequently seen by an orthopedic surgeon, [Dr. E] who recommended surgery. The claimant underwent spinal surgery on June 23, 2010.

EXTENT OF INJURY

The hearing officer's determination that the compensable injury extends to a lumbar disc HNP at L3-4, L4-5, and L5-S1; spondylolisthesis at L5-S1; and lumbar radiculopathy is supported by sufficient evidence and is affirmed.

The hearing officer noted in his Background Information that "[t]he degenerative disc disease is just that – a degenerative condition – and there is inadequate evidence that it was caused by, worsened, or aggravated by the compensable injury." The hearing officer specifically found that the degenerative disc disease did not arise out of or naturally flow from the compensable injury of [date of injury]. That finding was not appealed. We note that the hearing officer's Conclusion of Law No. 3 determined "[t]he compensable injury of [date of injury], extends to a lumbar disc [HNP], spondylolisthesis and degenerative disc disease/spondylosis at L3-4, L4-5, L5-S1 and lumbar radiculopathy." The hearing officer's first Conclusion of Law No. 4 (we note that the decision and order contains two conclusions of law that are both numbered 4), determined that the compensable injury of [date of injury], does not extend to degenerative disc disease at L3-4, L4-5, and L5-S1. It is clear from the hearing officer's discussion of the evidence that he was not persuaded the compensable injury included degenerative disc disease and his finding in that regard was not appealed. Therefore, we reform Conclusion of Law No. 3, striking "degenerative disc disease."

The claimant's surgeon, Dr. E in a medical note dated January 12, 2010, noted that his review of the MRI scan reveals L5-S1 spondylolisthesis with contained disc herniation rated as stage II with annular herniation, nuclear protrusion, disc desiccation consistent with T2-weighted image changes, and spinal stenosis. Dr. E went on to note that "[t]here are like findings at L4-5 and L3-4 with [HNP] but no spondylolisthesis." In subsequent notes Dr. E again noted that the spondylolisthesis was limited to the L5-S1 level of the claimant's lumbar spine. In a letter of causation dated August 30, 2011, Dr. E stated that the claimant's "trauma of the on-the-job injury of [date of injury]," was a causative factor and in within all reasonable medical probability caused the HNPs at L3-4, L4-5, and L5-S1 with spondylolisthesis at L5-S1. Dr. E did not opine that the compensable injury was a cause of or that the claimant even had spondylolisthesis at the L3-4 and L4-5 levels of the lumbar spine. Dr. E did not opine that the claimant had spondylosis at any level of the lumbar spine.

The x-ray of the claimant's lumbar spine dated September 23, 2009, noted there was mild anterior degenerative spondylosis at L2-3, L3-4, and L4-5. The x-ray noted that the spondylolisthesis was at the L5-S1 level. Flexion/extension x-rays dated September 24, 2009, gave as an impression segmental instability at L2-3, L3-4, L4-5, and L5-S1. An MRI was in evidence dated September 29, 2009. An EMG was performed on December 21, 2009, and noted an indication of bilateral L5 and S1 radiculopathy slightly greater on the right side. The findings noted in the operative report of June 23, 2010, included lumbar HNP at L3-4, L4-5, and L5-S1, subluxation spondylolisthesis at L5-S1 and subluxation L4-5.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709. S.W.2d 175 (Tex. 1986).

The Appeals Panel has previously held that proof of causation must be established to a reasonable medical probability by expert evidence where the subject is so complex that a fact finder lacks the ability from common knowledge to find a causal connection. Appeals Panel Decision (APD) 022301, decided October 23, 2002. *See also* Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007). To be probative, expert testimony must be based on reasonable medical probability. City of Laredo v. Garza, 293 S.W.3d 625 (Tex. App.-San Antonio 2009, no pet.) citing Insurance Company of North America v. Meyers, 411 S.W.2d 710, 713 (Tex. 1966).

As discussed above, the medical evidence that related the cause or aggravation of the claimant's spondylolisthesis to the claimant's compensable injury limited the opinion of the spondylolisthesis to the L5-S1 level. No doctor opines that spondylosis at the L3-4, L4-5, and L5-S1 level was caused or aggravated by the claimant's compensable injury. Accordingly, we reverse that portion of the hearing officer's determination that the compensable injury extends to spondylolisthesis of the L3-4, and L4-5 level and spondylosis at the L3-4, L4-5, and L5-S1 levels and render a new decision that the compensable injury of [date of injury], does not extend to spondylolisthesis of the L3-4, and L4-5 level and spondylosis at the L3-4, L4-5, and L5-S1 levels.

IR

The parties stipulated that the claimant reached MMI on February 2, 2011. Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Texas Department of Insurance, Division of Workers' Compensation (Division) shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors. 28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)) provides that the assignment of an IR for the current compensable injury shall be based on the injured employee's condition as of the MMI date considering the medical record and the certifying examination.

It was undisputed that [Dr. G] was appointed by the Division to examine the claimant and provide opinions regarding MMI and IR. The hearing officer found that the IR evaluation of Dr. G was performed in accordance with the Guides to the Evaluation

of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides). The hearing officer determined that the claimant's IR is 25% as assigned by Dr. G, placing the claimant in Diagnosis-Related Estimates (DRE) Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity.

We note that Rule 130.1(c)(3) requires that the doctor assigning the IR shall:

> (A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;
>
> (B) document specific laboratory or clinical findings of an impairment;
>
> (C) analyze specific clinical and laboratory findings of an impairment;
>
> (D) compare the results of the analysis with the impairment criteria and provide the following:
>
> > (i) [a] description and explanation of specific clinical findings related to each impairment, including [0%] [IRs]; and
> >
> > (ii) [a] description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.
>
> (E) assign one whole body [IR] for the current compensable injury.

The description and verification of DRE Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity states:

The patient meets the criteria of DRE lumbosacral category III and DRE lumbosacral category IV, that is, both radiculopathy and loss of motion segment integrity are present.

The description and verification of DRE Lumbosacral Category III: Radiculopathy states:

> The patient has significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements on the contralateral side at the same location. The impairment may be

verified by electrodiagnostic findings. See Table 71, p.109, differentiators 2, 3, and 4.

The description and verification of DRE Lumbosacral Category IV: Loss of Motion Segment Integrity states:

The patient has loss of motion segment integrity. Loss of motion segment or structural integrity is defined as at least 5 mm of translation of one vertebra on another, or angular motion at the involved motion segment that is 11° more than that at an adjacent motion segment. Loss of structural integrity at the lumbosacral joint is defined as at least 15° more angular motion than at the L4 and L5 motion segment.

In APD 030091-s, decided March 5, 2003, the Appeals Panel held that the AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy with greater than a 2 cm decrease in circumference compared with the unaffected side. That decision goes on to state that the findings of neurologic impairment may be verified by electrodiagnostic studies, but that the AMA Guides do not state that electrodiagnostic studies, showing nerve root irritation, without loss of relevant reflexes or atrophy, constitutes undeniable evidence of radiculopathy. *See also* APD 050729-s, decided May 23, 2005, and APD 051824, decided September 19, 2005. In APD 072220-s, decided February 5, 2008, the Appeals Panel held that to receive a rating for radiculopathy the claimant must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 cm or more above or below the knee, compared to measurements on the contralateral side at the same location. The atrophy or loss of relevant reflex must be spine-injury-related for radiculopathy to be rated.

The AMA Guides, Table 71 on page 3/109 for Loss of Motion Segment Integrity requires "[f]lexion and extension comparison roentgenograms show significant injury-related anterior-to-posterior translation of two adjacent vertebral bodies of 5 mm or more in the lumbar . . . ."

Dr. G's narrative gave as impressions the following: lumbar spine pain with degenerative disc disease, instability at several levels, herniated disc L4 and radiculopathy left. Dr. G did not consider all of the conditions that have been determined to be part of the compensable injury and did consider some conditions that were found to be excluded from the compensable injury and therefore his 25% IR cannot be adopted.

Dr. G notes in his narrative report that he placed the claimant in DRE Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity. Dr. G notes that "in going to page 102 [of the AMA Guides], there is a perfect example of

lumbar radiculopathy by EMG and the loss of segmental area." Although there is some indication in his report that Dr. G found diminished reflexes in the claimant's ankle ("[a]nkle shows the right ankle to be decreased and the left ankle absent,") Dr. G appears to assign impairment for the claimant's radiculopathy solely on the results of the EMG. Further, the narrative signed by Dr. G does not explain why the claimant meets the criteria for DRE Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity. Therefore, the 25% IR in evidence from Dr. G cannot be adopted because he does not consider the entire compensable injury and failed to explain why the claimant meets the criteria for DRE Lumbosacral Category V.

An alternative rating from Dr. G is in evidence but assesses impairment based on a compensable injury of only a lumbar sprain. Therefore, it cannot be adopted because it is not based on the entire compensable injury.

There are three other certifications in evidence from [Dr. T], who examined the claimant as a carrier-selected required medical examination doctor. Dr. T examined the claimant on July 11, 2011, and certified that the claimant reached MMI on February 2, 2011, the stipulated date in each of the alternative certifications. Dr. T provided three alternative certifications considering the following conditions: (1) lumbar strain/sprain; (2) lumbar spinal pathology; and (3) lumbar spinal pathology and urological symptoms. We note that no condition of urological symptoms or sexual dysfunction was at issue in the CCH.

The certification assessed by Dr. T for the lumbar strain/sprain cannot be adopted because it is based only on the consideration of a lumbar strain/sprain and does not consider the entire compensable injury.

Dr. T does not indicate what, if any, spinal pathology he considered in assessing the claimant's IR. Dr. T's rating cannot be adopted because it cannot be determined whether or not he considered the entire compensable injury.

No other certification is in evidence. Therefore, the IR issue is remanded to the hearing officer.

REMAND INSTRUCTIONS

The hearing officer is to determine if Dr. G is still qualified and available to be the designated doctor and if so, Dr. G is to rate the claimant's entire compensable injury (including the extent-of-injury conditions affirmed in this decision) as of the agreed date of MMI of February 2, 2011, using the AMA Guides. If Dr. G is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed to determine the claimant's IR for the compensable injury. The hearing

officer is to provide the designated doctor's response to the parties and allow the parties an opportunity to present evidence and respond. The hearing officer is then to make a determination on the claimant's IR.

SUMMARY

We affirm the hearing officer's determination that the compensable injury of [date of injury], does not extend to degenerative disc disease at L3-4, L4-5, and L5-S1.

We affirm that portion of the hearing officer's determination that the compensable injury of [date of injury], extends to HNP at L3-4, L4-5, and L5-S1. We affirm that portion of the hearing officer's determination that the compensable injury of [date of injury], extends to spondylolisthesis at L5-S1. We affirm that portion of the hearing officer's determination that the compensable injury of [date of injury], extends to lumbar radiculopathy.

We reverse that portion of the hearing officer's determination that the compensable injury extends to spondylolisthesis of the L3-4, and L4-5 level and spondylosis at the L3-4, L4-5, and L5-S1 levels and render a new decision that the compensable injury of [date of injury], does not extend to spondylolisthesis of the L3-4, and L4-5 level and spondylosis at the L3-4, L4-5, and L5-S1 levels.

We reverse the hearing officer's determination that claimant's IR is 25% and remand the IR issue to the hearing officer for further action consistent with this decision.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

[CITY CLERK]
[ADDRESS]
[CITY], TEXAS [ZIP CODE].

Margaret L. Turner
Appeals Judge

CONCUR:

Cynthia A. Brown
Appeals Judge

Thomas A. Knapp
Appeals Judge